



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

RGOI AMBULATORY SURGERY CENTER
5520 NORTH C STREET
MCALLEN TX 78504

Respondent Name

TEXAS DEPARTMENT OF
TRANSPORTATION

Carrier's Austin Representative Box

Box Number 32

MFDR Tracking Number

M4-04-6952-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...Texas Dept. of Transportation's reimbursement is far below the fair and reasonable requirements mandated by the Texas Legislature. RGOI will show that the most common CPT code performed (29888) is reimbursed at an average of 81.7% of billed charges, as demonstrated by RGOI's statistical analysis...Indeed, even an analysis of the lowest payments of CPT code 29888 yields an average reimbursement of 69.2% of billed charges." **"In addition to the statistical analysis, RGOI has also provided the standard evidence that the MDR itself has deemed to be the best proof of fair and reasonable: recent copies of the EOB's of other carriers..."**A review of these recent EOBs for identical CPT codes finds an average allowable at 88% of charges."

Amount in Dispute: \$20,755.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Reimbursement based on Medicare's current ASC Group Payment and Policies. Included in another service performed on same date."

Response Submitted by: TXDOT, P.O. Box 149148, Austin, TX 78714-9148

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
February 27, 2003	Outpatient Surgery	\$20,755.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on March 4, 2003. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on March 21, 2003 to send additional documentation relevant to the fee dispute as set forth in the rule.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - M-Reimbursement based on 100% of the current Medicare ASC Group Payment rate for the primary surgical procedure. All subsequent surgical procedures reimbursed at 50% of the current Medicare ASC Group rate.
 - O-Previous recommended amount has not been changed.

Findings

1. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
2. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
3. 28 Texas Administrative Code §133.307(e)(2)(A), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires that the request shall include "a copy of all medical bill(s) as originally submitted to the carrier for reconsideration..." Review of the documentation submitted by the requestor finds that the request does not include a copy of the medical bill(s) as submitted to the carrier for reconsideration. The Division concludes that the requestor has not met the requirements of §133.307(e)(2)(A).
4. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
 - The requestor's position statement asserts that "...Texas Dept. of Transportation's reimbursement is far below the fair and reasonable requirements mandated by the Texas Legislature. RGOI will show that the most common CPT code performed (29888) is reimbursed at an average of 81.7% of billed charges, as demonstrated by RGOI's statistical analysis...Indeed, even an analysis of the lowest payments of CPT code 29888 yields an average reimbursement of 69.2% of billed charges." **"In addition to the statistical analysis, RGOI has also provided the standard evidence that the MDR itself has deemed to be the best proof of fair and reasonable: recent copies of the EOB's of other carriers..."**A review of these recent EOBs for identical CPT codes finds an average allowable at 88% of charges."
 - The requestor states "RGOI will show that the most common CPT code performed (29888) is reimbursed at an average of 81.7% of billed charges, as demonstrated by RGOI's statistical analysis...Indeed, even an analysis of the lowest payments of CPT code 29888 yields an average reimbursement of 69.2% of billed charges."
 - The Division has previously found that a reimbursement methodology based upon payment of a percentage of a hospital's billed charges does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, which states at 22 *Texas Register* 6276 that:

"A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the

Commission and system participants, and would require additional Commission resources.”

Therefore, a reimbursement amount that is calculated based upon a percentage of a hospital’s billed charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.

- The requestor’s position statement further asserts that **“In addition to the statistical analysis, RGOI has also provided the standard evidence that the MDR itself has deemed to be the best proof of fair and reasonable: recent copies of the EOB’s of other carriers....**A review of these recent EOBs for identical CPT codes finds an average allowable at 88% of charges.”
- In support of the requested reimbursement, the requestor submitted redacted explanations of benefits, and selected portions of EOBs, from various sample insurance carriers. However, the requestor did not discuss or explain how the sample EOBs support the requestor’s position that additional payment is due. Review of the submitted documentation finds that the requestor did not establish that the sample EOBs are for services that are substantially similar to the services in dispute. The carriers’ reimbursement methodologies are not described on the EOBs. Nor did the requestor explain or discuss the sample carriers’ methodologies or how the payment amount was determined for each sample EOB. The requestor did not discuss whether such payment was typical for such services or for the services in dispute.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

12/28/2011

Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and***

Decision together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.